STATE TRAUMA ADVISORY BOARD
MINUTES
May 2, 2005
150 North 18th Avenue, Conference Room 540-A

Members Present:		**Members Absent**:
Ben Bobrow (Chairman)	Charles Frank Allen	Jeff Farkas
Stewart Hamilton	David Leinenveber	Steve Thompson
Alex Wilcox	David Bank	Philip Johnson
Scott Petersen	Mark Venuti	Dan Judkins
Debbie Johnston	Rich Thacher	Anslem Roanhorse
Robert Galey	Bill Ashland	Stuart Alt
		John Porter

I. CALL TO ORDER

Ben Bobrow, Chairman, called the special meeting of the State Trauma Advisory Board to order at 10:15 a.m. Bill Ashland, Stewart Hamilton, and Alex Wilcox attended by conference call. A quorum was present.

Members of the STAB Work Group present: Terrence Loftus, Thomas Wachtel, Marcia Barry, and Daniel Caruso.

II. OLD BUSINESS

A. Discussion and Action on Revised Draft Rules for Trauma Designation

The Board reviewed each rule section by section.

Section R9-25-1301 – R9-25-1304 – no changes were identified.

Section R9-25-1305 – Dr. Allen asked whether someone is physically reviewing a trauma center that applies for provisional designation. Dr. Allen expressed concern about a hospital acting as a trauma center for 12 months without anyone inspecting it first. Sarah Harpring stated that the Department has interpreted the statutes to authorize a voluntary designation, so that designation is not required in order to provide trauma services. Because of that, it will still be possible for a hospital to provide trauma services without first obtaining designation. Provisional designation was included in the rules to allow for a peculiarity of the central region. Regional protocols will not allow a patient to be taken to a hospital for trauma care unless that hospital is designated (once the designation process is in place). 12 months was selected because unless you have been providing services for at least 9 to 12 months, it is not possible to get the American College of Surgeons (ACS) to come out and do a site visit. This is to accommodate new and relatively new trauma centers. This language is not intended to authorize or encourage a health care institution to offer trauma services without obtaining designation.

A question was asked if there is a statement that the institution certified that they meet the criterion in the application or the RFP.

Sarah stated that the rules currently are drafted to require an attestation that the trauma center will meet the state standards at the Level of destination sought.

It was suggested that the rules could require an ACS consultation visit as a prerequisite for provisional designation. A question was asked if it would be something that Level III trauma centers would want to do, because of the expense. Debbie Johnston stated that she did not believe that they would.

Discussion ensued regarding how to change the wording about who can apply for provisional designation.

After discussion, it was recommended to change the wording to allow provisional designation for health care institutions that do not have at least 12 consecutive months of trauma data. Otherwise, a health care institution needs to obtain an initial designation.

R9-25-1306 – R9-25-1310 – the Board did not identify any changes.

R9-25-1311(A)(1) – Bill Ashland pointed out that it provides that the Department can conduct unannounced on-site surveys as part of an investigation.

It was suggested that if the on-site survey is unannounced, it is not known if someone would be there to answer the surveyor's questions.

Discussion ensued about the merits of having announced versus unannounced on-site surveys for for-cause investigations and the fact that the rule merely allows for a survey rather than requiring one.

It was recommended to change the wording to read:
"may conduct an announced or unannounced on-site survey."

R9-25-1312 – R9-25-1315 – no changes were identified.

Exhibit I –Arizona Trauma Center Standards

Dr. Loftus asked whether Vascular Surgery is required and whether it should be expressly added in the criteria. Vascular Surgery is not listed in Exhibit I.

Sarah stated that she had spoken to Dr. Coscia at ACS regarding this question. Dr. Coscia acknowledged that Vascular Surgery is not listed in the standards and stated that ACS requires it for a Level I and Level II, and it is covered under General Surgery.

There was concern that the administrator of a health care institution would not put Vascular Surgery on their call schedule and would not provide call pay for it because it is not listed in the rules. It was discussed that the General Surgeon has to be capable of providing Vascular Surgery or has to be able to have access to a Vascular Surgeon.

Dr. Petersen recommended that Vascular Surgery not be added to the rules. This would result in an added expense to each hospital. Trauma Surgeons should be able to handle the Vascular Surgery and should be credentialed in it, but the rules should not specifically require it.

The Board's consensus was not to add Vascular Surgery.

Dr. Loftus asked that there be more of an operational definition for the word "collaboration," as used in reference to the different collaborative programs. Concern was expressed about how an ACS site reviewer will determine whether you meet this criteria as a collaborative effort, whether there is a checklist, and how it will be proven.

Discussion ensued about the meaning of collaborative program and how this should be clarified.

It was recommended that a tool be developed for conducting the survey to state standards, which will clarify any areas for which there are questions about the meanings of the criteria. This tool will be adopted as a substantive policy rather than a rule. It was also recommended that STAB and the STAB Work Group be involved with ADHS in developing this tool.

It was also recommended that, in the footnotes discussing collaborative programs, ADHS be added after Regional Councils as an entity that could sponsor or coordinate a collaborative program.

It was asked if the new ACS criteria would include volume criteria for pediatric Level I trauma centers. The current ACS Standards state that a Level I Pediatric trauma center does not have to meet the current Level I volume criteria. Answers to Frequently Asked Questions C3 states – There are no volume requirements for Level I trauma centers caring only for children.

The new ACS criteria will include volume criteria for pediatric Level I trauma centers. It was recommended that the rules not include volume criteria for pediatric Level I trauma centers.

Dr. Allen expressed concern about Footnote #7 – the meaning of promptly available, both because of the 45 minutes and because it is based on the time of patient arrival rather than notification. Sarah explained that the earlier draft used the idea of responding in a time that meets the needs of the patient, but AZHHA believed that this was too subjective. This was an attempt to clarify the requirement, and because 30 minutes is considered to be immediate in some places, it seemed that prompt would need to be longer than 30 minutes. It did not seem like 30 minutes could be both immediate and prompt. AZHHA had suggested that the rule use "reasonable," but reasonable is too vague and would need to be defined so that it would be clear and concise and acceptable to the Governor's Regulatory Review Council.

Discussion ensued about the appropriate response time to use for physician specialists and, if response is based on patient need, who will determine what the patient needs.

It was recommended to change the wording to read:
"no later than 45 minutes after notification, based on patient need."

Sarah asked if response times expressed elsewhere from time of patient arrival rather than time of notification should be changed. It was recommended that the other response times not be changed.

Footnote #14 – Dr. Petersen asked if "pediatric patients" was defined somewhere else because the term "children" in the draft rules was changed to "pediatric." Sarah responded that the term is not defined in the rules and was changed to be consistent with the use of pediatric elsewhere.

Discussion ensued about defining pediatric patient.

It was recommended that pediatric patient not be defined, and that if the Department is required to define "pediatric" later in the rulemaking, it be defined to mean "someone who is under the age of 18 and who meets the healthcare institution's definition of a pediatric patient."

Sarah identified an inconsistency between Item E.6.a. Footnote #18 and Item E.6.b.ii., created when the Department added Level II to Footnote #18.

Discussion ensued about how to resolve the inconsistency in whether operating room staff is required to be in-house for a Level II trauma center.

It was recommended that the references to Level II trauma centers be removed from the Footnote #18 requirements for Level I trauma centers and that the information about Level II trauma centers from the ACS Gold Book's footnote be used as the requirement for Level II trauma centers. The result is that in a Level II trauma center, the operating room will be immediately available, but the operating room staff will be able to respond and will not need to be in-house. This has to be monitored by the performance improvement program.

Dr. Petersen asked where the 80% came from in Footnotes #15 and #16. Sarah explained that ACS Amendment 18 and Answers to Frequently Asked Questions F13 include the 80% threshold.

It was recommended that Footnote #20 be eliminated so that in-house CT technicians are required in all Level I trauma centers and Level II trauma centers.

Dr. Petersen asked if the rules make an exception for the in-house presence of a surgeon at a pediatric Level I trauma center. Sarah explained that this was a discussion item at the last STAB Meeting, and STAB did not approve making a change for that.

The intention is to file a Notice of Proposed Rulemaking by June 10, 2005. It will be published as a Notice of Proposed Rulemaking on July 1, 2005. The Department will then have to hold at least one oral proceeding and will be having a public comment period for at least 30 days. Then the Department intends to file with the Governor's Regulatory Review Council, for their October agenda.

A motion was made by Dr. Petersen, seconded by Mark Venuti, to approve the draft document as amended today. **Motion carried**.

III. CALL TO THE PUBLIC

No one came forward.

IV. ADJOURNMENT

The meeting adjourned at 11:45 a.m.

V. NEXT MEETING

The next regularly scheduled STAB meeting is September 22, 2005.

Approved by: State Trauma Advisory Board

Date: September 22, 2005